Authorization for Evaluation and/or Treatment of a Minor child Unaccompanied by Parent/Legal Guardian

I, ______________________________, give permission for the following adults:
(Name of Parent/Guardian)

- ____
  Name of Adult Accompanying Child Phone Number Relationship to Child
- ____
  Name of Adult Accompanying Child Phone Number Relationship to Child
- ____
  Name of Adult Accompanying Child Phone Number Relationship to Child

to accompany my child ______________________________ in my absence and authorize
(child's name and DOB)
treatment for my child in accordance with the office policy of Tots & Teens Pediatrics. This includes. bringing the child into the office of Tots & Teens Pediatrics, providing a history of present illness, disclosing protected health information, witnessing any physical exam completed by the provider, and making medical decisions about treatment of the patient. This adult has the responsibility to relay any diagnosis, treatment plan and prescription(s) to the parent or legal guardian mentioned above. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments and this consent may be revoked by me at any time in writing.

I ____ **DO** ____ **DO NOT** give permission for the above adults to make decisions regarding vaccines.

This authorization is effective from: ______________ to ______________.
(effective date) (end date)

Emergency Contact Information for Parents/Guardians:
Where/how can you be contacted in case of emergency______________________________
Phone: ______________________

Parent or Legal Guardian's Signature: ______________________ Date______________